REPORT OF

IMPLEMENTATION OF L. 2005 S.B. 500

AS IT RELATES TO THE FIRST STEPS PROGRAM

SUBMITTED BY:

MISSOURI DEPARTMENT OF INSURANCE,

FINANCIAL INSTITUTIONS

& PROFESSIONAL REGISTRATION

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The Department of Insurance, Financial Institutions and Professional Registration (DIFP) is required under § 376.1218.9 RSMo, to annually report to the Missouri General Assembly by January 30 for the previous program year, on:

1. The number of children receiving First Steps' services who have private insurance coverage.
2. The total amount of moneys paid on behalf of such children by private health carriers and health benefit plans.

This report is the second annual report to the Missouri Legislature. It covers calendar year 2007 data and addresses specific issues the Department of Elementary and Secondary Education (DESE) encountered with the direct billing of private insurance carriers for mandated coverage. The authority for insurance mandates relating to First Steps is found in § 376.1218, RSMo, and 20 CSR 400-2.170.

First Steps is an early intervention program for children from birth to age three years operated by DESE and funded by the following appropriations:

- State Funds: 57%
- Federal Funds: 30%
- Medicaid Reimbursement: 6%
- Insurance Funds: 6%
- Family Cost Participation Funds: 1%

These funding sources support a variety of federally mandated services including the four services requiring state mandated insurance coverage: physical therapy, occupational therapy, speech/language therapy and assistive technology. First Steps is a federal entitlement program authorized under Part C of the Individuals with Disabilities Education Act (IDEA) to provide a system for meeting the needs of infants and toddlers with developmental delays and to support a family's capacity to enhance its child's development. First Steps provided some service to approximately 7,390 children in FY 2007. Approximately half (3,651) of these children were determined eligible for First Steps services and received services as outlined in an Individualized Family Services Plan (IFSP). The balance of the children served in FY 2007 received only evaluation/assessment services and were found not to be eligible for the program.

A First Steps participant's private insurance information is collected at the System Point of Entry (SPOE) regional office. Approximately 60% or 2,182 of the program's participants have private insurance coverage. While Missouri's statute mandates insurance coverage for four First Steps services, federal IDEA regulations *do not allow a state to require* program participants to utilize their personal insurance coverage to pay for services outlined in the IFSP. Missouri law requires participants who are unwilling to provide access to their private insurance to pay an increased Family Cost Participation obligation.

Some types of health benefit plans under which First Steps children may be insured are exempt from this state insurance mandate, including "self-funded" ERISA-qualified health benefit plans. It is estimated that as many as 60% of health plans in Missouri are exempt from the coverage required under § 376.1218.7, RSMo.

As indicated in the funding appropriations above, private insurance reimbursement provides approximately 6% of the funding stream to First Steps. Insurance carriers may elect one of three payment options to meet their obligation. This report addresses each option separately and discusses the applicable impact to the First Steps program.

Insurance carriers must *annually elect* one of three specific payment options:

1. *bulk payment of $500,000* in total on behalf of all affiliated insurers under common ownership;
2. *percentage payment* of ½ of 1% of the carriers direct written premium for health benefit plans as declared on their most recent annual financial statement; or
3. *direct claims billing* up to a maximum of $3,000 per year per child for the four identified services.

Options 1 and 2 require the carriers to make a single payment to First Steps annually to satisfy their obligation to First Steps for that calendar year. Option 3 requires the carrier and DESE staff/contractor to process claims on a regular basis to track amounts paid by child and by policy throughout the year.

Based on two years of implementation, Options 1 and 2 (single annual payments) are the most common elections and generate the majority (in excess of 97%) of insurance proceeds for First Steps. Minimal cost was incurred to implement Options 1 and 2.

Option 3, direct claim billing, generates less than 2% of the annual insurance revenue. The cost to the First Steps program to develop a direct claim billing system has been $500,000 so far. Several problems impact the successful utilization of this option. Over 85% of First Steps claims were denied or rejected on the first submission. This was due in part to how the claims were submitted to the insurance carriers by DESE and due in part to the complexity of carriers' adjudication systems. Growing pains and the learning curve on both sides have impacted the successful utilization of the direct claims billing option. Legitimate reasons exist for some denials such as coverage provided by self-funded health plans or coverage not in force for the date of treatment. However, DESE receives a number of inappropriate denials or rejections such as incompatible claim coding and no authorization for care. Many denials extend beyond five months. It takes manual effort on the part of DESE and its contractor to process the claims and claim data. This process adds to the administrative costs for the First Steps program.

When insurers choose direct claim billing, it creates several disadvantages for the families of First Steps children. The disadvantage causing the most concern for the First Step families is that some insurance policies place a limit or cap on the number of therapy sessions allowed in a given calendar year. Families are concerned that if sessions are used to cover First Steps services, no further sessions will remain under the insurance policy for sessions needed to meet non-First Step therapy needs. Many of the children in First Steps have extensive medical needs in addition to the developmental needs covered by this program. At this time, the First Steps program has anecdotal evidence from the regional First Steps offices to support this concern. The program plans to establish a way to quantify this concern for the 2009 annual report.

The following tables address specific data for calendar year 2007:

2007 INSURER AND HMO FIRST STEPS PAYMENTS

	$500,000 Assessment (Bulk Payment)	1/2 of 1% of direct written premium (Percentage Payment)	Direct Claim Billing	Not Applicable	No Response	Total
Number of Carriers	9	82	36	176	36	**339**
Number of Children	662	1108	412			**2182**
Claims Billed			$168,791			**$168,791**
Payments Received	$1,000,000	$528,529*	$37,264			**$1,565,793**

*Of the carriers paying this amount, slightly more than half are paying $3,000 or less. Therefore, their payment to the program is less than what their obligation would be if they had only one child in the program.

MAXIMUM POSSIBLE PAYMENT IF ALL CARRIERS SELECTED THE DIRECT CLAIM BILLING OPTION

Number of Children	Maximum allowable payment per year per child	Maximum possible direct claim billing
2182	$3,000	$6,546,000

Option 1: Bulk Payment: Two groups, representing nine separate carriers, some of which are the largest health insurers in Missouri, opted for a single bulk payment of $500,000. This payment made on behalf of their affiliated insurers and HMOs generated $1,000,000 for First Steps.

Option 2: Percentage Payment: Eighty-two (82) insurers and HMOs made payment of ½ of 1% of the applicable direct written premium reported on their annual statement, generating $528,529 for First Steps.

Option 3: Direct Claim Billing: In fiscal year 2007, 36 insurers and HMOs elected to pay First Steps by direct claim billing. Of those, 12 carriers had First Steps children and were billed on a direct claim basis. Unfortunately, 85.54% of direct claims were initially denied by the insurance carrier (5,764 of 6,738 claims submitted). Total direct bill insurance claims for calendar year 2007 were $168,791. Of that amount, $37,264 or 22% was paid to First Steps. The average number of days from First Step's submission to the insurance carrier to receipt of the electronic payment documentation was 83 days. The fastest turnaround time from claims submittal to receipt by First Steps was 19 days, the longest turnaround time was 154 days (almost 5 months). For the 82.1% of claims that have not been paid to date, the number of days outstanding from claims submittal to some action on the part of the carrier exceeds 154 days and grows daily.

Direct claim billing, if fully paid ($168,791), would account for less than 1% of the potential total revenue to First Steps. As of January 1, 2008, First Steps identified approximately $15 million in

expenditures for direct services in calendar year 2007. Direct claim billing, if received, could provide approximately 1.13% of the funding for expenditures for early intervention direct services provided by the program. Direct claim billing, based on actual receipts, provided funding for slightly over 1/5 of 1% of the total expenditures for early intervention services provided by the program.

Thirty-six (36) insurers or HMOs failed to provide payment election information. First Steps billed this group of non-responders as though they elected to make a one-time payment of ½ of 1% of their direct written premiums, but received no payments. Non-responders could have a fairly significant impact on insurance receipts for First Steps, but the impact is unknown since these carriers failed to respond to the statutory requirement to participate in First Steps.

One hundred and seventy-six (176) carriers self-reported they had no applicable exposure (no insured's under the age of five) or their lines of business were exempt from the mandate and had no claim exposure. This group represents almost 52% of the target pool of carriers with a potential to be subject to state-mandated insurance coverage for First Steps children.

DIFP's Insurance Market Regulation Division is collecting insurance carrier information from DESE in order to evaluate the need for market conduct exams on the carriers identified to have a claim adjudication problem, carriers failing to respond to provide payment election information, or those indicating they have no applicable exposure. DIFP historically needs a minimum of two years of data for market analysis in order to establish a possible business practice violation by an insurer or HMO. DIFP has been working directly with DESE since the inception of the mandate in January 2006 to put insurance carriers on notice of this obligation for coverage, to determine the need for the annual election by carrier and to facilitate compliance in payment by whichever means an insurance carrier chooses.